Return to Play: Concussion Clearance Form

To be completed by a licensed health care provider

YOUTH ATHLETE'S NAME	DATE	SPORT
DATE OF BIRTH AGE	SCHOOL/TEAM	

REPORTER ☐ PATIENT ☐ PARENT ☐ CAREGIVER(S) ☐ SIBLING(S) ☐ FIRST RESPONDER ☐ COACH ☐ OTHER:

INJURY CHARACTERISTICS

Date/Time of Injury

Injury Description

Location of Impact: ☐Lt Frontal ☐Rt Frontal ☐Lt Parietal ☐Rt Parietal ☐Occipital ☐ Crown ☐ Neck ☐ Indirect Force

Are there any events just BEFORE the injury that you have no memory of? ☐YES ☐NO

Are there events just AFTER the injury that you have no memory of? ☐YES ☐NO

Loss of Consciousness: ☐YES ☐ NO If yes, for how long? Seizures: ☐ YES ☐ NO

Initial Signs: ☐dazed or stunned ☐confused about events ☐answered questions slowly ☐repeated questions ☐forgetful

SYMPTOM CHECKLIST - *Since the injury has the person experienced any of these symptoms?*

PHYSICAL		COGNITIVE		SLEEP	
Headache	Yes | No	Confusion	Yes | No	Drowsiness	Yes | No
Nausea	Yes | No	Feeling slowed down	Yes | No	Sleeping less than usual	Yes | No
Vomiting	Yes | No	Difficulty concentrating	Yes | No	Sleeping more than usual	Yes | No
Balance problems	Yes | No	Difficulty remembering	Yes | No	Trouble falling asleep	Yes | No
Dizziness	Yes | No	EMOTIONAL		Exertion: Do symptoms worsen with:	
Visual problems	Yes | No	Irritability	Yes | No		
Fatigue	Yes | No	Sadness	Yes | No	Physical Activity? ☐ YES ☐ NO	
Sensitivity to light	Yes | No	More emotional	Yes | No		
Sensitivity to noise	Yes | No	Nervousness	Yes | No	Cognitive Activity? ☐ YES ☐ NO	
Numbness	Yes | No				

Refer to the emergency department with sudden onset of any of the following:

* Headaches that worsen
* Seizures
* Focal neurologic signs
* Looks very drowsy/can't be awakened
* Repeated vomiting
* Slurred speech
* Can't recognize people or places
* Increasing confusion or irritability
* Weakness or numbness in arms/legs
* Neck pain
* Unusual behavioral change
* Change in state of consciousness

PLEASE NOTE:

1. **Athletes are not allowed return to practice or play the same day that their head injury occurred.**
2. **Athletes should never return to play or practice if they still have ANY symptoms.**
3. **Athletes, be sure that your coach and/or athletic trainer are aware of your injury, symptoms, and the contact information for the treating physician.**

MEDICAL PROVIDER RETURN TO SCHOOL/PLAY RECOMMENDATIONS - This return to school/play is based on today's evaluation.

☐ Do not return to school

☐ Return to School on _____

☐ No Academic Modifications Needed

☐ Academic Modifications Needed (Complete Return to School Form)

☐ No activity or sports restrictions are necessary.

☐ No sports practice, physical education, or competition at this time.

☐ May start return to play progression under the supervision of the health care provider. (Complete Return to Play Form)

☐ Must return to medical provider for final clearance to return to competition

LICENSED HEALTH CARE PROVIDER NAME	SPECIALTY (CIRCLE ONE) MD DO PA APN Other:
OFFICE ADDRESS	SIGNATURE
PHONE NUMBER	DATE

This information is provided in accordance with the guidance found in Act 1435 of the 2013 Arkansas General Assembly.